

portionately augmented, and this must lead to the numerical increase as well as to the high percentage of hæmoglobin, until a balance is struck between the production and the destruction of the blood-corpuscles."

EARLY DELIRIUM IN TYPHOID.

ASCHAFFENBOURG (*Archives de Neurologie*, March, 1895) reports the case of a female, aged thirty years, who entered the hospital in a state of great agitation, with disordered ideas of a very marked character, so that she was incapable of understanding what was said to her. She had insomnia, hallucinations, and walked as if drunk. The pulse was rapid.

The hallucinations, as well as the agitation and the intellectual obtuseness, became more and more marked, and reached their height about the fifth day. At this time, the evening temperature being 38.4° C., typhoid fever was suspected, and the symptoms soon became typical. The delirium disappeared, but the patient gradually sank and died in collapse. The autopsy confirmed the diagnosis.

Out of seventeen cases of early delirium in typhoid in the literature, in seven the delirium preceded the fever—the latest period at which it was observed being the end of the first week, the delirium lasting, as a rule, only a few days. Six patients of the seventeen reported died. Early delirium in typhoid presents itself under two forms, both of which have as a common symptom great intellectual obtuseness.

In the one form we have delirium similar to that seen in the later stages of the disease. The patients imagine that they are being electrified, etc.; they are restless and at times violent, or perhaps may be in a condition of torpor. Very often there is a primary stage of agitation followed by a stage of torpor.

In the second form there is absolute confusion both of the ideas and actions. The patients sing, pray, or dance, and may be either gay or depressed. As to causation, Aschaffenburg inclines to the view that the typhoid bacilli secrete a poison which has the power of diminishing the body-heat and exciting the cerebral cortex like a narcotic alkaloid.

HÆMOGLOBINURIA FROM MUSCULAR EXERTION.

LEE DICKINSON (*Clinical Society's Transactions*, 1894) reports three interesting cases of hæmoglobinuria from exertion. All of the cases occurred in young, healthy individuals after severe exertion, the hæmoglobinuria being transitory and unaccompanied by any other symptoms, except in one case where there was slight frequency of micturition.

The author points out that there exists a condition which may be called functional hæmoglobinuria, in which there seems to exist an abnormal liability of the blood-corpuscles to destruction, the hæmoglobinuria occurring on very slight exertion.

In his cases, however, the normal blood was destroyed, the hæmoglobinuria here produced being comparable to that occurring in burns and after certain poisons.

A case is mentioned in which, in a boy dying during a run, the only patho-

logical lesion found was a disintegration of the red corpuscles; the author suggests that had the boy lived long enough he would have presented hæmoglobinuria, and that his cases differed from this only in degree.

The hæmoglobinuria in these cases is explained by the destruction of the red corpuscles in the circulation and the subsequent elimination of the hæmoglobin by the kidneys.

How the blood-disintegration occurs is not fully known, but carbonic acid is probably largely concerned in the process, as it is known that this gas, in excess in the system, may profoundly modify the blood and the tissues associated with it. Cyanosis did not, however, accompany the over-exertion in all the cases.

LEUCOCYTOSIS IN HYPERTROPHIC CIRRHOSIS OF THE LIVER.

In a short note on this point HANOT and MENNIER (*Comptes Rendus de la Société de Biologie*, February 1, 1895) call attention to the fact that they have always regarded this disease as of an infectious nature, and consider the leucocytosis as further evidence of infection.

They cite five cases of hypertrophic cirrhosis with chronic icterus, in each of which blood-counts were made on various occasions, and an excess of leucocytes always found. In none of these cases was there any extra hepatic inflammation which could cause a leucocytosis.

The examinations showed that the number of leucocytes per cubic millimetre varied from 9000 to 21,800; that is to say, an average of 15,000.

The blood-count of a number of cases of alcoholic cirrhosis showed an average of 6600 leucocytes per cubic millimetre.

The authors conclude that hypertrophic cirrhosis is the only disease of the liver in which a leucocytosis is present, except carcinoma, in which they have found as many as 40,000 white corpuscles to the cubic millimetre.

CONFUSION BETWEEN DISTENDED GALL-BLADDER AND MOVABLE KIDNEY.

HENRY MORRIS (*British Medical Journal*, February 2, 1895) points out that though on first thought there is not much resemblance between these two affections, the one is often confounded with the other.

The fact that both affections are much more common in women is noted, and the fact that the right kidney is much more movable than the left increases the chances of error. The symptoms common to both are pointed out.

Both may present as a tumor in the right hypochondriac and umbilical regions, and the physical characteristics of the tumor from either cause may be similar. The tumor may be movable in either case, and in either case the percussion-note overlying it may be resonant or dull. Both diseases may cause dyspeptic symptoms or give rise to colic. Either may cause jaundice, gastric intestinal catarrh, or even peritonitis. In neither case is the condition of the urine a reliable guide. The conditions of the gall-bladder, which tend to render the confusion more probable, are elongation with a reniform outline, mobility, or downward displacement of the liver, with a retroflexed gall-bladder under the viscus, causing the displaced bladder to feel like a loin rather than an abdominal tumor.